

Anesthesiology and the Public Option: Economic effects of two alternative public option payment approaches on anesthesiologist payment and anesthesia practices

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The public option concept has emerged as a prominent health care reform alternative. Current public option proposals have the potential to significantly reduce payments to anesthesiologists and could negatively affect the current economics of anesthesia practices and increase consolidation of anesthesiology practices among large national anesthesia groups and hospitals.

Executive Summary

At its core, a public option is a health plan option operated by a federal, state, or local government that competes directly with the existing private insurance market. By design, one of the primary value propositions of a public option – whether driven by government regulation or the private market – is lower prices for consumers and other purchasers. These lower prices are typically enabled by reducing payments to providers relative to the level of prevailing commercial payment rates. Reducing the amount paid to providers reduces the cost of providing covered benefits, which in turn reduces insurance premiums. To determine the potential impact of public option plans that reduce physician payments on anesthesiologists and the market as a whole, we evaluated claims data for private health coverage in 2018, and modeled the effects of alternative approaches to mandated payment levels. Our analysis identified three major themes.

Relative to commercial payments, Medicare pays anesthesiologists less than it pays other physicians.

Current public option proposals have considered setting provider payments based on a multiple of traditional Medicare fee schedules. Such an approach could be implemented as a single multiple that applies to all specialties or using a variable model where the multiple varies depending on the physician specialty. While a single multiple of Medicare payment rates may be appealing for administrative simplicity, our research suggests it would likely have different effects on anesthesiologists compared to most other specialties. For example, anesthesiologist payments under Medicare are 34% of prevailing commercial payment rates, while payments to all other physicians are 75% of commercial payment rates, on average. This comparison is shown in Figure 1.

FIGURE 1: DISTRIBUTION OF MEDICARE PAYMENTS RELATIVE TO COMMERCIAL MARKET IN-NETWORK PAYMENTS

PROVIDER TYPE	SERVICE PAYMENT PERCENTILE			
	25 TH	50 TH	75 TH	AVG
ANESTHESIOLOGISTS	24%	35%	70%	34%
ALL OTHER PHYSICIANS	67%	85%	105%	75%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

For half of non-anesthesia physician services, Medicare would pay at least 85% of commercial market rates and would exceed commercial market rates for over 25% of services. For commercial market anesthesiology services, Medicare would pay at most 70% of current commercial payment rates for three quarters of these services. As a result, the current economics of anesthesia practices would be disproportionately affected should a public option utilize a uniform Medicare payment rate benchmark multiple. While this situation may not be unique to physician anesthesiologists, the relative magnitude of payment disruption under a uniform benchmark multiple could result in significant changes to the future of anesthesiology practices.

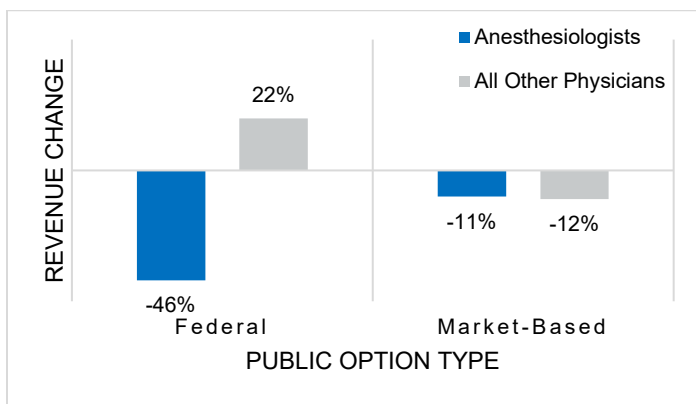
The relative differential between Medicare and commercial payment rates to anesthesiologists compared to all other

physicians is rooted in the decades-old Medicare payment formula unique to the practice of anesthesia services.¹ The difference in payment rates for anesthesiologists relative to other physicians shown in Figure 1 is indicative of the disproportionate impact on anesthesiologists for services that transition from the existing private coverage market to a public option that utilizes a fixed multiple of Medicare fees.

Using the same multiple of Medicare payments for all physicians exposes anesthesiologists to greater potential payment reductions than a method that retains relative values in the commercial market.

A public option operated by the Medicare program (a “federal” public option) is most likely to use a fixed multiple of Medicare payments as a benchmark,² while a public option driven by states and operated by private insurers (a “market-based” public option) is more likely to benchmark costs using an overall payment rate target blended across all services, permitting payment rates to vary as a percentage of Medicare among different service categories.³ This means that a benchmark level such as 160% of Medicare would have different economic effects on anesthesiologists relative to other physicians under each option as shown in Figure 2.

FIGURE 2: REVENUE REDUCTION FOR SELECTED SERVICES UNDER PUBLIC OPTION ALTERNATIVES TIED TO 160% OF MEDICARE RELATIVE TO PREVAILING COMMERCIAL PAYMENT RATES



Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

¹ Johnathan Pregler, Vijay Saluja, Mahesh Vaidyanathan, Christopher (Kit) Young, Jonathan Gal, Sharon Merrick, Christopher Troianos; The 33% Problem: Origins and Actions Committee on Economics 33% Workgroup Report ASA Economic Strategic Plan Initiative—October 2020. *ASA Monitor* 2020; 84:28–33 doi: <https://doi.org/10.1097/01.ASM.0000724064.38204.e5>

² As discussed in this early public option paper, a participation requirement may be necessary to offer a robust enough network under a federal program..

These results reflect the same overall payment level across all services – the difference is in the relative payment levels for services by Medicare and the private market between provider types. To the extent that Medicare payments may not reasonably represent the difference in costs between services provided by anesthesiologists and services provided by other physicians, use of a fixed multiple of Medicare as under a federal public option will produce significantly greater payment reductions for anesthesiologists relative to other physicians.

Anesthesia practices may have a more limited set of tools to address broad payment reductions than other physicians. Negative financial effects on anesthesiology practices could accelerate the trend of practice consolidations.

Ultimately, the impact of a public option on overall provider revenue depends on the level of adoption of the public option plan. While both federal and a market-based public options will likely expand coverage options on the Patient Protection and Affordable Care Act’s (ACA) exchanges, a federal option is more likely to have broad geographical reach and availability, particularly if it builds on current Medicare provider participation and associated payment rates. This may lead to availability of a public option in areas where broad provider networks may not otherwise be viable at this payment level for providers due to the magnitude of the required payment reduction. This dynamic appears to be particularly significant for anesthesiologists. As shown in Figure 3, roughly nine tenths of the US population live in metropolitan statistical areas (MSAs) where anesthesiologists would experience an average payment reduction of 30% or more on public option enrollees under a fixed payment multiple approach relative to prevailing payment rates in the private health coverage market.

FIGURE 3: PERCENTAGE OF US POPULATION RESIDING IN AN MSA WITH A GIVEN PAYMENT REDUCTION FOR ANESTHESIOLOGISTS BY PUBLIC OPTION TYPE

PUBLIC OPTION TYPE	PAYMENT REDUCTION AT A 160% OF MEDICARE BENCHMARK			
	BELOW 10%	10% - 20%	20% - 30%	ABOVE 30%
FEDERAL (FIXED % OF MEDICARE)	8%	1%	2%	89%
MARKET-BASED (AGGREGATE % OF MEDICARE)	55%	33%	10%	2%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

<https://www.urban.org/sites/default/files/publication/30756/411984-Getting-to-a-Public-Option-that-Contains-Costs-Negotiations-Opt-Outs-and-Triggers.PDF>

³ Washington’s Cascade Care program has such a target – 160% of Medicare payment rates – at RCW 41.05.410(g)(i), with the stipulation that primary care services must be paid at least 135% of Medicare payment rates.

As a practice area, anesthesiologists are payer agnostic – patients do not typically schedule their own anesthesia services, leaving anesthesia practice volume and payer mix dependent on procedures scheduled by other physicians. As such, patient volume and payer mix for anesthesiologists is primarily dependent on the individuals who require anesthesia care – a factor largely beyond the anesthesiology practice’s control.

Absent any growth in the insured population, the aforementioned dynamic means payment reductions are more likely to directly reduce overall practice revenue. This revenue reduction in turn may decrease the appeal of anesthesiology as a practice area, particularly if anesthesiologists are more adversely impacted by a public option than other specialties.⁴ On the other hand, if a public option succeeds in providing coverage to the uninsured, the overall demand for healthcare services, including anesthesiology services, could increase. Altogether, this creates a challenging balance between service supply and service demand – one that could tip toward a reevaluation of the economics of anesthesia practices.

As anesthesiology practices may be limited in their ability to affect service volume, they may explore broader adjustments to their business plans. This could result in an increase in provider practice consolidation, which has been shown to enable price increases in the commercial market, potentially offsetting some of the revenue reductions that may arise from a public option.⁵

As policymakers and providers evaluate possible designs for public option plans that might be introduced at the Federal or state/local levels, careful consideration should be given to issues of patient access and affordability of care. This will ensure the broader goal of providing affordable coverage to more individuals is balanced against ensuring the availability of key services, such as anesthesiology, to all patients.

⁴ Shanafelt TD, Raymond M, Kosty M, et al. Satisfaction With Work-Life Balance and the Career and Retirement Plans of US Oncologists. *Journal of Clinical Oncology*. 2014;32(11):1127-1135. doi:10.1200/jco.2013.53.4560

⁵ The Kaiser Family Foundation maintains a useful summary of current research on provider consolidation. See <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>.

Background on a public option

In order to understand the analysis performed in this paper and our selection of public alternative options, it is important to understand key variables in the development of a public option. In this section we set out two plausible and distinct alternatives and explore how they may meaningfully vary with an emphasis on features that may affect anesthesiology practices.

THE HISTORY OF THE PUBLIC OPTION

The concept of a public option can be traced back to health reform efforts in California at the turn of the century. Policymakers sought to drive down premiums and reduce healthcare costs by making the government an active competitor in the private market. It remained a state-level issue until the latter 2000's. John Edwards' health platform in the 2008 presidential election sought public options in each state, and the federally run public option emerged in the ensuing health reform discussion as part of the crafting of the ACA in 2009 and 2010.⁶ While the public option was ultimately excluded from the ACA, it has remained a policy consideration, and the federally run public option emerged as the centerpiece of President Biden's healthcare policy platform.⁷

WHAT COULD A PUBLIC OPTION LOOK LIKE?

The primary characteristic of a public option is that parameters are fully prescribed by the government. While there are many ways to design a public option, the principal structural decision is who operates the public option plan – the government or the private market. But there are other key decisions to make with regards to administration, benefit design, provider payment rates, eligibility, and premium subsidies. Provider payment rates in particular are a major point of focus, as they are the primary mechanism that can be used control government spending levels

A Federal Public Option

The Biden campaign's platform outlined a federally operated public option.⁸ Here are its components:

Administration: The Medicare program would operate and set parameters for the program.

Benefit Design: Members would be able to select from a variety of benefit designs, including a benefit design with no deductible. Figure 16 illustrates different benefit designs we evaluated for purpose of this paper. All benefit designs considered are

calibrated to the gold level of coverage using the HHS 2021 Actuarial Value Calculator.⁹

Payment Rates: We assume that payment rates will be set as a fixed multiple of the Medicare fee schedule.

Eligibility: All individuals who are not eligible for other federal health programs will be eligible to purchase coverage under the Federal Public Option.

Premium Subsidies: Premiums for the Federal Public Option would be determined according to a sliding scale, set to 0% of household income at or below 138% of the federal poverty level (FPL) and capped at 8.5% of household income for any individual. The public option plan would not be used to determine the level of subsidies for individuals purchasing other plans in the ACA marketplace.

A Market-Based Public Option

States have begun exploring market-driven public option programs, and our example is modeled on Washington's Cascade Care program.¹⁰

Administration: States determine specific benefit designs, but the insurers develop and administer the plans pursuant to state requirements.

Benefit Design: Benefit designs are largely standardized and set by the state. Figure 17 illustrates three copay benefit designs and three coinsurance benefit designs evaluated for the purpose of this analysis. Benefit designs cover a range of gold, silver, and bronze metal tiers using the HHS 2021 Actuarial Value Calculator.¹¹

Payment Rates: Payment rates are set in aggregate and measured against the Medicare Fee Schedule, but individual provider payment rates are not prescribed. In this paper, we assume that payment rates will be set as a multiple of the Medicare Fee Schedule and that participating providers will agree to uniform payment rate adjustments across a state, preserving relativities between given providers and geographies within that state.

Eligibility: Only individuals shopping on the individual market Exchange would be eligible to sign up for the public option.

Premium Subsidies: Premiums for the Market Based Public Option would be determined under the current ACA marketplace rules. Exchange carriers would be permitted to offer non-public

⁶ http://assets.milliman.com/ektron/Evaluation_of_a_Colorado_public_option.pdf

⁷ The public option is a feature of President Biden's proposed American Families Plan. <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/>

⁸ <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>

⁹ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AV-Calculator.xlsx>

¹⁰ <https://www.hca.wa.gov/about-hca/cascade-care>

¹¹ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AV-Calculator.xlsx>

option plans, but could not offer leaner silver plans, with the goal that the public option plans determine the ACA benchmark premium.

Relative to a federal public option, a market-based public option has significantly more variable components. Different states are likely to take differing approaches to these key choices, and many states may not choose to become involved in this type of offering. The resulting patchwork of plans and regulations could limit appeal and create confusion amongst consumers, which in turn could limit its impact. At the same time, state-specific variations may align better with the needs and desires of state residents and policy priorities of local governments.

Current payment for anesthesia services

In whatever form it takes, the public option is likely to change many dynamics for the estimated 199 million individuals who would be either uninsured or participate in the private health insurance market in 2022.¹² From a provider perspective, one of the primary considerations is the effect that a public option may have on current payment levels (e.g., revenue), and this in turn will be driven in significant part by changes to payment rates. To evaluate the changes to payment rates, it is important to understand current payments for anesthesia services in the commercial market. Given the tendency of policy proposals to focus on payment rates relative to Medicare, it is equally important to understand Medicare's payment structures for these same providers. As the public option will primarily affect services that would otherwise be covered under private market health coverage, we illustrate payment levels relative to prevailing payment rates in the commercial market.

COMMERCIAL MARKET PAYMENTS

Most commercial market payment agreements are the result of two-sided negotiations. Payers contract with physicians and medical groups under a variety of different arrangements, including fee-for-service, risk sharing, bundled payments, and capitated agreements. In some cases, providers may subcontract services to other physicians and medical groups – in this case, information for the subcontracted physician may not be reflected in the payer's claims record, although the service encounter itself will be reflected.

Like any other physician specialty, anesthesiologists have a wide variety of payment arrangements. Some anesthesiologists and anesthesia practices negotiate fee-for-service rates based on

case rates equal to a percentage of Medicare fees or discounts off billed charges. Anesthesiology practices can receive subsidies directly from the facilities with which they work, most often to ensure availability of services across specialties to support varying clinical needs, such as trauma care and labor and delivery. In other cases, the anesthesiology practice receives support for services it provides to the facility to optimize clinical throughput, quality, and safety.¹³ As Medicare and Medicaid do not in general provide payment specific to anesthesia in these instances, hospitals and anesthesiologists work together to ensure that patients have access to anesthesia care when needed, which can take the form of standalone payments outside of the typical provider-insurer relationship. Anesthesiologists and hospitals have also worked together to develop value-based models of care and other alternative payment models.

We reviewed Milliman private market claims data for 2018 for a specific range of procedure code codes that represent anesthesia services 00100 through 01999. In our data, anesthesiology providers perform roughly 80% of these services, with all other physician specialties combined performing about 20% of these services.¹⁴ Medicare payment rates relative to commercial payment rates for these services are similar among anesthesiologists and all other physicians, with small variations between the individual and group market. Figure 4 and Figure 5 show how payment rates vary for the employer and individual markets.

FIGURE 4: PERCENTILES FOR MEDICARE PAYMENTS RELATIVE TO COMMERCIAL MARKET IN-NETWORK SERVICE PAYMENTS FOR ANESTHESIA SERVICES IN THE EMPLOYER MARKET

PROVIDER TYPE	SERVICE PAYMENT RATE PERCENTILE			
	25 TH	50 TH	75 TH	AVG
ANESTHESIOLOGY PROVIDERS	23%	31%	43%	30%
ALL OTHER PHYSICIANS	22%	33%	43%	25%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

FIGURE 5: PERCENTILES FOR MEDICARE PAYMENTS RELATIVE TO COMMERCIAL MARKET IN-NETWORK SERVICE PAYMENT RATES FOR ANESTHESIA SERVICES IN THE INDIVIDUAL MARKET

PROVIDER TYPE	SERVICE PAYMENT RATE PERCENTILE			
	25 TH	50 TH	75 TH	AVG
ANESTHESIOLOGY PROVIDERS	23%	34%	51%	33%
ALL OTHER PHYSICIANS	21%	31%	43%	24%

California. Anesthesiology. 2019 Sep;131(3):534-542. doi: 10.1097/ALN.0000000000002819. PMID: 31283739; PMCID: PMC7583316.

¹⁴ This 20% may include anesthesiologists practicing as part of multispecialty groups.

¹² <https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf>

¹³ O'Connell C, Dexter F, Mauler DJ, Sun EC. Trends in Direct Hospital Payments to Anesthesia Groups: A Retrospective Cohort Study of Nonacademic Hospitals in

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

In both figures, we see that Medicare payments for anesthesiologists are about one third of what they currently receive in the commercial market. Payment rates in the individual market are about 10% lower than payment rates in the employer market, resulting in higher Medicare payments as a percentage of individual market payments than as a percent of employer market payments. On a percentile basis, anesthesiology providers tend to receive somewhat more than other providers from Medicare relative to the commercial market. For these other providers, this payment relativity is much less than the payment relativity shown in Figure 1, as other providers would receive significantly more from Medicare relative to commercial market payment rates for their non-anesthesia services. Additionally, we note that Medicare payments for anesthesiology are slightly higher as a percentage of individual market payment rates, which is indicative of somewhat lower commercial market payment rates in the individual market relative to the group market. Furthermore, this payment reduction does not carry over to non-anesthesia providers who provide anesthesia services.

MEDICARE PAYMENTS

Under Medicare, payment for anesthesia services is made under Part B, and specifically part of the Physician Fee Schedule. As with other Part B services, payment is for the most part determined by the procedure, rather than by the type of physician who performs the procedure. However, Figure 6 shows that the majority of commercial services submitted for payment by anesthesiologists are for anesthesia services, so our discussion here pertains to all anesthesia services under Medicare.

FIGURE 6: SERVICES PERFORMED BY ANESTHESIOLOGISTS

SERVICE TYPE	% OF TOTAL ANESTHESIA VOLUME AT 100% OF MEDICARE
ANESTHESIA SERVICES	79%
OTHER SERVICES	21%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

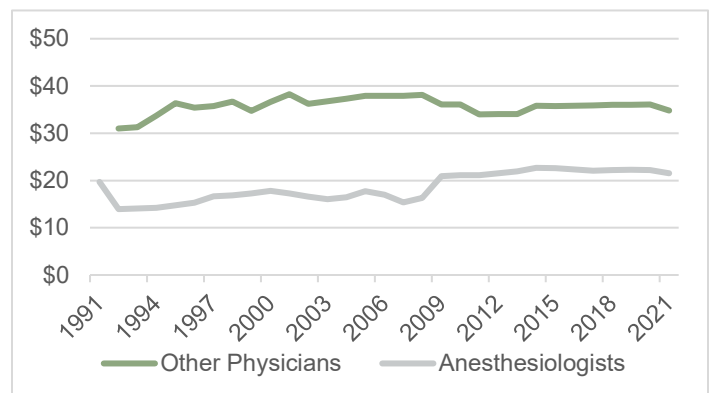
Prior to 1991, Medicare payments for physician services were based on prevailing charges, which led to significant variations in costs for a given service depending on provider, specialty, and geography, broadly similar to the private market today. Payments for anesthesia services were revised to be based on a uniform

¹⁵ Public Law 100-203, passed December 22, 1987, <http://www.gpo.gov/fdsys/pkg/STATUTE-101/pdf/STATUTE-101-Pg1330.pdf>

¹⁶ <https://www.congress.gov/bill/101st-congress/house-bill/3299/text>

relative value guide under the Omnibus Budget Reconciliation Act (OBRA) of 1988,¹⁵ with similar provisions applied to all other Medicare physician services by the Omnibus Budget Reconciliation Act of 1989.¹⁶ The resulting resource-based schedule that varies provider payments by the relative value of the service, as determined by the resource-based relative value scale (RBRVS). Under RBRVS, payment for a given service is determined by the base cost per relative value unit, referred to as the conversion factor, multiplied by the number of relative value units associated with the service. The existing anesthesia relative value guide was integrated into the new RBRVS value scale as an intra-specialty set of relative values, and a unique anesthesia conversion factor was determined by cross-linking three specific anesthesia services to three quite different services used to develop overall physician relative values. The limited nature of this service linkage and the resulting valuation difference between anesthesia services and other physician services led to an overstatement of total anesthesia relative value units. The revenue neutrality element of the fee schedule then required an offsetting reduction to the anesthesia conversion factor, resulting in a base conversion factor for anesthesiologists of \$13.46 in 1992, roughly 30% lower than the base conversion factor for 1991 of \$19.27, and representing a corresponding 30% reduction in anesthesia payments under Medicare despite retaining a resource-based payment system.¹⁷ While there have been changes to the relative value scale over the years that seek to restore some of this valuation differential, the anesthesia conversion factor remains about a third lower than the general conversion factor used for all other services on the Medicare Physician Fee Schedule, as illustrated in Figure 7.

FIGURE 7: ANESTHESIA AND PHYSICIAN CONVERSION FACTORS, 1991-2021



Source: Medicare Physician Fee Schedules and supporting materials published by the Center for Medicare and Medicaid Services

¹⁷ This topic is discussed in some depth in http://www.csaq.org/docs/default-source/history-of-anesthesia-articles/history-articles/pauker-a-history-of-rbrvs-part2-2006.pdf?sfvrsn=d864c146_2

Figure 7 The anesthesia conversion factor has increased by 9% from 1991 to 2021, much lower than inflation as measured by than the 99.5% growth in the consumer price index over that same time span.¹⁸ Over the years, anesthesiologists have sought adjustments to the Medicare anesthesia conversion factor to better balance anesthesia compensation under Medicare against private payer rates, but revenue neutrality requirements applied to the overall annual physician fee schedule update limit the ability for anesthesia providers (or any other physician specialty) to achieve payment rate increases under Medicare as these must generally be offset by reductions in payments to other groups of providers. One example of this dynamic is the statutory increase in payments for evaluation and management (E/M) services in the 2021 physician fee schedule, which originally had the effect of reducing payments for more technical provider specialties such as anesthesia by almost 10%, although congressional action in December 2020 reduced this impact to roughly 2% for 2021.¹⁹ Ultimately, Medicare payment rates are not solely a measure of medical cost – they can reflect policy goals such as revenue neutrality or tie rates to another non-medical cost index – and specifying benchmark rates using Medicare as a baseline exports any relative value distortions induced by Medicare payment policy to other markets.

IMPLICATIONS WHEN IMPLEMENTING FEE SCHEDULE AS A PERCENTAGE OF MEDICARE

The difference in conversion factors under the Medicare Physician Fee Schedule has a significant implication for any analysis of commercial payment rates against the Medicare Fee Schedule, which we do in this paper. Policy proposals focus on Medicare payments for a variety of reasons, but one of the general underlying assumptions is that Medicare pays all providers equitably. A full analysis of this assumption is beyond the scope of this paper, but many anesthesiologists maintain a viewpoint that Medicare payment rates are inadequate to cover their costs.²⁰ When Medicare payments are insufficient to cover the costs of providing services, then an actual cost baseline for commercial market payment rates would already start meaningfully above 100% of Medicare payment rates – as an example, if Medicare only pays 80% of costs, then an actual cost baseline would be 125% of Medicare payment rates. To the extent that this occurs, using Medicare as a baseline for payment rate analysis for these providers would meaningfully overstate their fee schedule ratio relative to a comparison to a true cost-based ratio.

Consider the following example: Two services cost \$150 in the commercial market, but Medicare pays \$75 for the first and \$100 for the second. The first service would be said to be paid at 200% of Medicare while the second would be said to be paid at 150% of Medicare. If we believe that Medicare equitably assigned resource values between these two services, then we would say that the first service is overpaid in the commercial market relative to the second. However, if we believe the two services are of equal resource value consistent with commercial market prices, then we would instead say that Medicare underpays the first service relative to the second. As we have already pointed out, anesthesia commercial payment rates are notably higher than other physician services as a percentage of Medicare. The extent to which this is driven by any structural inequities in the disjoint between the general conversion factor and the anesthesia conversion factor in Medicare is unclear, and this paper does not opine as to which set of payment rates is more appropriate. Our primary conclusion, rather, is that Medicare pays less for anesthesia services than the commercial market relative to other physicians, and this means that options that may seek to align commercial market payment structures more closely to Medicare payments will disproportionately impact providers with lower Medicare payment rates relative to commercial payment rates such as anesthesiologists. Policy makers exploring payment structures for commercial market health care reform options such as a public option should consider the extent to which those payment structures appropriately reflect the value of different services and providers, rather than taking any single set of rates as a de facto baseline.

PAYMENT RATES UNDER MEDICAID

Medicaid payment rates tend to be the lowest rates paid in any given state. These rates are often set in statute as a percentage of Medicare payments, potentially with a custom relative value scale or utilizing a fixed year's Medicare Fee Schedule to increase cost predictability and limit future cost growth. Average payments as a percentage of Medicare vary widely, but payments for anesthesiologists tend to be at a similar or higher multiples of Medicare relative to overall physician payment (though still typically at or below Medicare), which suggests that relative to Medicare, Medicaid (like the commercial market) pays anesthesiologists more than it pays other physicians. However, as payments seldom exceed Medicare rates, any revenue insufficiency under Medicare is compounded for Medicaid programs.

¹⁸ <https://www.in2013dollars.com/us/inflation/1991?amount=1>

¹⁹ The payment rate reductions and the Congressional response are discussed in more detail in this Milliman whitepaper. [E/M-erging payment rates: Effects of 2020 federal funding legislation on the 2021 Medicare Physician Fee Schedule \(milliman.com\)](#)

²⁰ As an example, see <https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2019/05/asa-voices-concerns-about-medicare-payment-rates-as-part-of-historic-hearing-on-medicare-for-all-legislation>.

As anesthesiologists are particularly likely to participate in Medicaid²¹, this can contribute to a greater need for higher payment rates in commercial coverage to balance out any revenue shortfalls in government health programs. Generally, we anticipate that there will be limited interaction between Medicaid payment rates for anesthesiologists and other providers and a public option, particularly given Medicaid's placement as the lowest-cost payer. There may be some upward pressure on Medicaid rates if reductions in provider revenue under a public option show signs of creating a reduction in provider supply. However, states are more likely to maintain fee schedules at levels similar, or less, than current given their heavy budgetary constraints.

Financial impact of the federal public option

As noted previously, a federal public option may establish a fee schedule (i.e., payment rates) as a percentage multiplier to Medicare. Per the prior discussion, this is an assumption that Medicare's fee schedule accurately captures relative service value. Most policy discussions that consider the use of Medicare payment rates in the commercial market assume that something greater than 100% of Medicare rates will be paid, but the exact level is less clear. Proposals have called for or examined 105% of Medicare,²² 115% of Medicare,²³ and 125% of Medicare.²⁴ The Cascade Care program in Washington state benchmarks against 160% of Medicare. But establishing a uniform Medicare benchmark percentage affects different provider types in different ways, as shown in Figure 8.

FIGURE 8: PERCENTAGE OF PRIVATE MARKET SERVICES THAT WOULD SEE A REVENUE REDUCTION AT SPECIFIED PERCENTAGES OF MEDICARE PAYMENT

PROVIDER TYPE	MULTIPLE OF MEDICARE PAYMENT							
	100%	105%	115%	125%	140%	160%	180%	200%
ANESTHESIOLOGY	95%	94%	93%	92%	91%	89%	87%	85%
OTHER PHYSICIANS	82%	76%	66%	56%	44%	32%	24%	19%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

²¹ Limited data exists for provider participation in Medicaid, but the nature of anesthesia as an ancillary service requires anesthesiologists to enroll in state Medicaid programs to receive payment for services rendered to patients they receive with Medicaid.

²² <https://americashealthcarefuture.org/wp-content/uploads/2019/11/FTI-Public-Option-Issue-Brief-FINAL.pdf>

²³ <https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending>

²⁴ <https://www.healthaffairs.org/doi/10.1377/hblog20140826.041002/full/>

A federal public option is more likely to tie payment rates in the public option directly to Medicare, which means that providers may have limited ability to avoid payment reductions, particularly if the public option gains widespread adoption. Many professional service providers may be content with these public option payments – 68% of commercial market physician services cost less than 160% of Medicare as an example – but anesthesiologists are more likely to be negatively impacted. In turn, a federal public option would have significant negative impacts on revenue for many, as shown in Figure 9.

FIGURE 9: AVERAGE REVENUE REDUCTION AT SPECIFIED PERCENTAGES OF MEDICARE PAYMENTS

PROVIDER TYPE	MULTIPLE OF MEDICARE PAYMENTS							
	100%	105%	115%	125%	140%	160%	180%	200%
BILLING SERVICE								
ANESTHESIOLOGY	-66%	-65%	-61%	-58%	-53%	-46%	-40%	-33%
OTHER PHYSICIANS	-24%	-20%	-13%	-5%	6%	21%	37%	52%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

Again, non-anesthesiology physicians are likely to see smaller revenue reductions – and even potential revenue increases – from a federal public option. Affected anesthesiology providers could see significant reductions in their own revenues. Generally, inpatient payment rates also tend to be higher than physician payment rates relative to Medicare in the commercial market.²⁵ As such, inpatient facilities are likely to see equivalent or greater reductions, which could force facilities to focus their own revenues on hospital-provided services, leading to downstream negative impacts on anesthesiologists they partner with.

The impact on a specific anesthesiology practice will vary based on several factors, including the previous mix of patients served by the practice, the portion of those who switch from private coverage to the federal public option,²⁶ and the specific impact on their payments. Figure 10 illustrates how practice revenue may be impacted, assuming that there are no changes to other payment rates.

²⁵ The RAND corporation suggests that Medicare pays approximately 40% of what commercial payers do. See Whaley, Christopher M., Brian Briscoombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020. https://www.rand.org/pubs/research_reports/RR4394.html

²⁶ The Biden campaign has also proposed that individuals aged 60 and over be eligible for Medicare, which would put additional pressure on anesthesia practices who serve individuals age 60-65.

FIGURE 10: ESTIMATING IMPACT TO ANESTHESIOLOGY PRACTICE REVENUE IF PAYMENT IS SET AT 125% OF MEDICARE

	EXAMPLE 1	EXAMPLE 2	EXAMPLE 3
COMMERCIAL VOLUME	50%	50%	30%
MEDICARE VOLUME	30%	30%	50%
MEDICAID / OTHER VOLUME	20%	20%	20%
PERCENTAGE SHIFTING	5%	20%	5%
PRACTICE REVENUE IMPACT	-2.2%	-8.8%	-1.6%

Calculations assume practice has national average commercial payment rates for commercial business and does not see any shifts in services beyond movement of individuals to the public option.

As this figure shows, greater private market exposure and / or greater adoption of the public option among private market members can lead to larger impacts on practice revenue. In practice, this may be offset to some degree by additional enrollment if the public option successfully appeals to the uninsured, however, affected practices (which are likely to include many anesthesia practices) likely have limited ability to offset public option-related revenue reductions via shifting costs to the commercial market, as commercial market plans will now have to compete with the public option. Instead, this could put additional downward pressure on commercial market rates, creating even larger reductions in practice revenue than illustrated above.

In Figure 10 example 2 illustrates the significant impact a 20% migration from a practice's commercial membership to the public option will have on an anesthesiology practice. To date, the ACA exchanges have not significantly disrupted the group market. This may be partially due to generally higher costs for similar benefits for non-subsidized individuals in the individual market relative to the group market. To the extent that the public health option mandates a fee schedule that is substantially lower than prevailing commercial fee schedules, this could create a much more appealingly priced product relative to the prevailing group coverage options available in the market today. The tipping point for employers to drop coverage remains unknown and will vary by the health profile of the employer. In the case of an aggressive public option fee schedule, it seems highly plausible that the presence of an attractive option in both price and benefits in form of the public option could be a catalyst for employers to exit the business of providing medical coverage to their employees.

²⁷ https://www.aha.org/system/files/2018-05/2018-AHA-Chartbook_0.pdf

²⁸ <https://www.amga.org/about-amga/amga-newsroom/press-releases/2019-operations-and-finance-survey/>

However, adoption of the public option is unlikely to be universal – consumers have demonstrated an appetite for choice and employers typically consider their health plan as a key employee retention strategy. As such, some element of the current private market is likely to remain as a boutique offering alongside the public option, even if the public option is hugely successful, though the size of this residual market may be limited. It is likely that segments of the private market that more directly compete with the public option will settle into payment contracts similar to the rates offered under the public option, much as has occurred in the Medicare Advantage market relative to Medicare fee for service payments.

In summary, payment rates under a federal public option will be the key factor in understanding the magnitude of impact a federal public option may have on the entire commercial market. There is some potential for increased enrollment if the public option appeals to the uninsured, however most of the change is likely to come as enrollment shifts from private coverage to the public option. Moreover, the effects of the fee schedule level relative to Medicare are likely to have non-linear impacts on the current individual and group market as that level approaches current Medicare rates. This in turn could result in even greater reduction in overall payments for anesthesiologists and other providers.

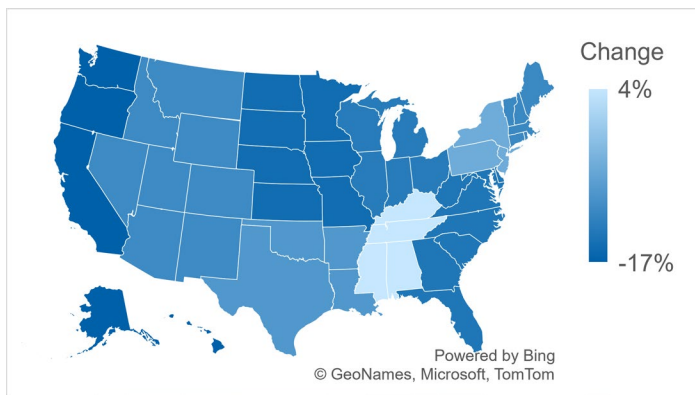
Financial impact of market-based public option

A market-based public option makes a notable contrast to the federal public option in its assumption regarding payment equity – namely, that the private market quantifies the relative value of different services and settings more effectively than Medicare does. This may be supported by financial results. Hospital operating margins were about 8% in 2016²⁷ and independent practice associations made a profit of about 1% relative to physician salaries.²⁸ The commercial market covers over half of Americans and pays for about one third of health care expenditures. If Medicare payments varied consistently with provider costs, we would expect that margins would be roughly equal to one third of the excess of the payment rate over 100% of Medicare, which was about 80% in 2018.²⁹ But these margins are much smaller and less dispersed than this simple analysis estimates, which implies medical provider margins are much closer to break even in the commercial market than payment rates relative to Medicare would suggest. As such, a market-based public option would most likely result in a proportional split

²⁹ For example, using the RAND study facility payment rates cited earlier, we'd expect blended payment for inpatient facilities to be $(247\% - 100\%) * 1/3 = 49\%$ higher than Medicare. An 8% margin then suggests average inpatient costs are close to 138% of Medicare overall – which would mean Medicare significantly underpays facilities.

of payment rate changes relative to Medicare in a given region. For purposes of this analysis, we have used states as the given region, though in practice, insurers often develop rates for service areas smaller than the state level and these smaller regions would serve to limit geographic rating variation within a state at a greater level than illustrated here. However, there is significant payment rate variation among states, and that means a market-based public option facing a given payment rate relative to Medicare would vary significantly in payment rate impact across the country, as shown in Figure 11.

FIGURE 11: AVERAGE STATE LEVEL PAYMENT RATE REDUCTIONS ACROSS ALL SERVICE TYPES TO MEET 160% OF MEDICARE TARGET, BY CENSUS DIVISION



Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

Within each census division, there is still notable variation, as show in Figure 12.

FIGURE 12: RANGE OF STATE-LEVEL REVENUE REDUCTIONS TO ACHIEVE 160% OF MEDICARE, BY CENSUS DIVISION

CENSUS DIVISION	RANGE OF STATE PAYMENT RATE CHANGES		
	AVERAGE	MINIMUM	MAXIMUM
EAST NORTH CENTRAL	-13%	-38%	0%
EAST SOUTH CENTRAL	4%	-6%	21%
MIDDLE ATLANTIC	-5%	-6%	-5%
MOUNTAIN	-11%	-30%	1%
NEW ENGLAND	-11%	-25%	0%
PACIFIC	-17%	-39%	5%
SOUTH ATLANTIC	-14%	-33%	12%
WEST NORTH CENTRAL	-15%	-24%	-8%
WEST SOUTH CENTRAL	-9%	-13%	11%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

By virtue of our assumption of equal reduction, all providers in a given state will see approximately the same revenue reduction in a market-based public option. Figure 13 shows the percentage of providers who would see a reduction and the average revenue impact under given payment rate targets for the market-based public option.

FIGURE 13: PROVIDER IMPACTS UNDER A MARKET-BASED PUBLIC OPTION AT GIVEN AGGREGATE MEDICARE BENCHMARK

	MULTIPLE OF MEDICARE PAYMENTS							
	100%	105%	115%	125%	140%	160%	180%	200%
AFFECTED SERVICES ¹	100%	100%	100%	100%	98%	89%	44%	14%
REVENUE IMPACT	-44%	-41%	-36%	-30%	-22%	-11%	-4%	-1%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.

¹ All providers in an affected state would see reductions

In aggregate, the payment rate impacts are similar to those under the federal public option, but there are key differences between these two public options, particularly as it pertains to anesthesiologists. In essence, a market-based public option would create less significant impact to anesthesia service revenue and to the revenue of facilities that provide supplemental income to anesthesiology practices because the payment structures under a market-based public option would not be disproportionately targeted at providers with higher revenue multiples (relative to Medicare).

Additionally, a market-based public option appears less likely to have mandatory provider participation provisions, which may lead to a lack of willing providers in high cost areas. This would allow providers in these areas to retain current private market pricing and payment structures and avoid negative revenue effects under the public option. However, it is uncertain how policymakers would respond to a lack of provider participation in these regions, and such a lack may lead to a push for some sort of participation requirement.

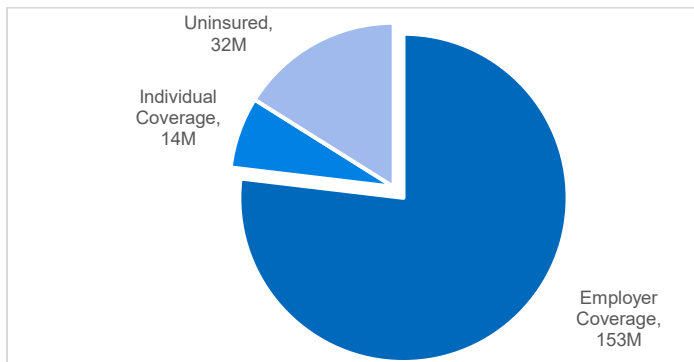
Public option penetration

One of the key factors anesthesiologists should consider when understanding how their practice will be impacted is the penetration of the public option into the commercial market. The federal and market-based public options have certain structural similarities, and we have discussed the financial implications in the previous two sections. In addition to the cost element, the ultimate level of adoption of either public option is dependent on two key parameters – eligible enrollees and provider participation.

ELIGIBLE ENROLLEES

As with any typical product, the size of the addressable market is a key consideration in how successful a public option will be. A public option is fundamentally driven by the desire to provide an additional competitive option to the existing private market that will appeal to the uninsured as well as to those who already purchase coverage. Under this assumption, the public option addresses the non-group market and the uninsured. However, as Figure 14 shows, the uninsured and the non-group market represent only about one quarter of those who are not covered by government health programs.

FIGURE 14: ESTIMATED INDIVIDUALS UNDER AGE 65 NOT ENROLLED IN A FEDERAL HEALTH PROGRAMS BY TYPE OF HEALTH INSURANCE COVERAGE, 2022³⁰



Source: Congressional Budget Office Health Coverage Projections

If employer-sponsored coverage is unaffected, this puts a practical limit on how many individuals will enroll in a public option. The uninsured are certainly a larger population than the current enrollment of the individual market, but the Congressional Budget Office estimates about two thirds of those individuals are currently eligible for other health coverage and choose not to purchase it. About three quarters of individuals without coverage do not have coverage because of cost,³¹ and this could limit the number of the newly covered if public option premiums are not significantly lower than current premiums in the individual market.

From a payment rate perspective, this means that a public option which focuses on the uninsured may have noticeable impacts on coverage, but less so on the employer-sponsored coverage that forms the backbone of the private health market. If this remains untouched, the total impact on providers could be limited. However, both the federal public option and the market-based

³⁰ <https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf>

³¹ <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=In%202019%2C%2073.7%25%20of%20uninsured,for%20financial%20assistance%20for%20coverage.>

public option have different avenues by which they can address employer coverage.

The federal public option as described by President Biden would permit employees to opt into the public option in lieu of their employer-sponsored coverage, presumably with some portion of the contribution paid by the employer. However, this migration comes with its own questions. Currently, employee healthcare contributions paid through payroll deductions are tax-deductible. If public option premiums are not tax-deductible, then employer premiums may not be directly comparable.³² Additionally, employer coverage may have more desirable cost-sharing or benefits. Employer-sponsored health care has long been considered an essential part of the employee compensation package, and while the public option may alter the value proposition to some degree, it seems likely that employers will continue to seek to provide additional value through health coverage as long as they can reasonably do so. Ultimately, the price differential between public option coverage and private market group coverage will play a key role in how an employer views this issue, and the greater the price differential, the fewer employers will remain in typical commercial arrangements.

The market-based public option may not directly address the employer market, but the recent expansion of health reimbursement arrangements (HRAs) to permit employers to direct employees into the individual market could lead employers to push employees towards the public option if plan prices are less than in the employer market. However, this may be less likely to occur, as typically, employees of large employers are healthier than the current individual market, as illustrated in Figure 15.

FIGURE 15: PAYMENT RATES TO ACHIEVE COST PARITY OF INDIVIDUAL MARKET COVERAGE VERSUS GROUP COVERAGE BY HEALTH STATUS OF LARGE EMPLOYERS RELATIVE TO INDIVIDUAL MARKET³²

	HEALTH STATUS OF LARGE EMPLOYERS RELATIVE TO THE INDIVIDUAL MARKET				
	BELOW 75%	75%-80%	85%-90%	85%-90%	ABOVE 90%
# OF STATES	7	12	12	9	8
AVERAGE MEDICARE PAYMENT TO MATCH RATES	126%	148%	149%	171%	179%

Source: Milliman analysis of 2018 claims data for private market major medical health coverage.
* Excludes Vermont, Massachusetts, and the District of Columbia

As such, payment rates under the public option would need to fall by over 15% in 31 states relative to current individual market

³² At an 18% marginal tax rate, a \$246 after tax public option premium would be equivalent to a \$300 (= \$246 / (1 - 0.18)) employee contribution through payroll.

payment rates in order for market-based public option premiums to be in line with current average group premiums in those states, which could limit the appeal of a market based public option in those states.

PROVIDER PARTICIPATION

An additional factor that will have significant impact on whether a public option is viable is the willingness of providers to participate in the program. In this regard, a market-based public option and a federal public option are likely to behave significantly differently.

By virtue of being driven by the private market itself, a market-based public option may not be able to compel provider participation. As such, the provider decision to participate in a market-based public option plan is likely to mirror the general provider participation decision – balancing the potentially meaningful enrollment of a public option plan, the payment rate under the plan relative to practice expenses, and any administrative burdens associated with participating in plans. Given the focus of such a public option on competition with existing coverage, the relationship between the aggregate payment rate target under the market-based public option relative to regional payment rates is likely to be strongly correlated with provider participation – providers generally may be willing to accept smaller reductions in payments, but regions that would experience larger reductions may have trouble attracting sufficient providers to offer a viable plan. This in turn means that premium rates under a market-based public option (or other public option design where participation is voluntary) may be unlikely to generate significant reductions in premiums and the corresponding desired increases in enrollment, barring enhanced subsidies. In the absence of a provision forcing providers to participate in a market-based public option, the ability for the market-based public option to achieve these kinds of savings may be limited.

By way of contrast, a federal public option would be more likely to mandate participation by tying it with Medicare, particularly if the public option is itself administered by Medicare. About 1% of non-pediatric physicians overall opted out of participating in the Medicare program in 2020, and anesthesiology providers are less likely than average to opt out.^{33,34} As such, it is likely that a federal public option will be more broadly available. The federal public option may still be somewhat sensitive to target payment rates – if acceptance of Medicare and the public option reduces provider payment rates beyond what a given provider can sustain financially, the provider may consider opting out of Medicare as one option. At the same time, the large population of Medicare

enrollees coupled with public option enrollees and the reduced enrollment in the private coverage market may limit the ability of some providers to maintain necessary utilization levels without relying on these federal programs. Additionally, the leverage available to the public option associated with tying participation to Medicare gives the federal public option more flexibility to reduce payment rates and potentially appeal to the broader employer market.

Relative to other types of providers, anesthesiologists face distinct challenges related to participation in the public option. Anesthesiologists typically accept all patients, potentially via an out-of-network benefit in the commercial market, but remaining out-of-network may be less viable in government health programs. As noted previously, the primary tactic a provider has in the face of unsustainable payment under a public option is to refuse to participate, but this may not be a viable option for anesthesiology practices. This in turn can lead to a meaningful reduction in overall practice revenue, with limited ability to recoup revenue through increased payments in other lines of business. Any offsetting increase to commercial payments only serves to accentuate the price difference between the public option (whether federal or market-based) and the commercial market, increasing the likelihood that individuals and potentially other market participants move into the public option.

Impacts on care demand and access

While much discussion of the public option centers on who gets covered and how much they pay, changes to the health coverage landscape that result from a public option may have meaningful impacts on the demand for health care services, and potentially on the ability of individuals to access this new care.

DEMAND FOR CARE

By its nature as an incremental addition on top of the current health care landscape, a public option is almost certain to increase demand for care. This increased demand will come from two primary sources – induced utilization from individuals who currently have leaner coverage and services for newly enrolled individuals who did not previously have coverage.

Induced utilization is driven by benefit design. Lower member cost-sharing and / or reduced health care service costs can increase an individual's propensity to seek services in otherwise identical situations. A market-based public option is less likely to result in significant induced utilization increases due both to payment rate considerations noted previously and greater variability in plan design offerings more in line with current

³³ <https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/>

³⁴ Many anesthesiology practices require their physicians to accept government programs, which is a significant part of the high participation rate for anesthesiologists.

individual coverage. If current members choose richer market-based public option plans than their marketplace selections, then some induced utilization could be present, but that may be unlikely if market-based public option plans cannot meaningfully distinguish themselves in terms of price. However, the federal public option proposed by President Biden during his campaign is expected to focus at the gold level of coverage, which is more generous than the silver and bronze plans that dominate current individual market coverage. Per Centers for Medicare and Medicaid Services (CMS) induced demand factors used in the individual market's risk adjustment program, this could lead to an additional 5% to 8% additional service utilization for members switching from silver, bronze, and catastrophic plans.³⁵ Members who switch from gold or platinum plans or from employer-sponsored coverage are unlikely to see an increase in utilization due to the switch, and could potentially see modest utilization decreases to the extent that federal public option coverage is leaner than their current coverage.

In 2013, healthcare spending for the uninsured on a per capita basis was about half of health care spending for those with private insurance.³⁶ With the expansion of the individual market since then, it is likely that this proportion has increased further, meaning that coverage of the uninsured is likely to create significant new service utilization. As noted previously, the market-based public option may have trouble reaching a significant number of the uninsured given the limited ability to reduce costs, particularly when coupled with the role that cost plays in a lack of insurance coverage.³⁷ The federal public option, however, may result in meaningful new coverage, particularly among the roughly 5 million uninsured individuals who had insurance in 2016 but have lost it in the years since.³⁸ This increase may be greater if the public option permits subsidized enrollment for households residing in states without Medicaid expansion and are therefore ineligible for the ACA premium subsidies due to the coverage gap.

ACCESS TO CARE

While the demand for services is likely to increase, particularly under a federal public option, the question of the public option's impact on access to care generally and to anesthesiology care in particular is less clear. The ongoing COVID-19 pandemic has highlighted the value of anesthesiology care and the role that

anesthesiologists play in acute care³⁹, but the anesthesiology specialty has also faced skepticism regarding the higher ratio of private payments to Medicare payments. The Government Accountability Office (GAO) recently published a report on anesthesia services and found that this higher ratio of private payments to Medicare payments is likely due to the strong negotiating position of providers, but that this did not interfere with access to anesthesia services in Medicare at Medicare payment rates.⁴⁰ However, there is a chance that a public option, and particularly a federal public option, may impact access to care, especially if payment rates for anesthesiology services under a public option are significantly lower than current payment rates in the commercial market.

Access to care is driven in large part by the available supply of providers who will accept a given program, and the Association of American Medical Colleges (AAMC) notes a potential shortfall of doctors by 2033 under the current health coverage system.⁴¹ The AAMC notes that increases in the supply of nurse anesthetists could offset some of the impact on anesthesiologists, but ultimately there is already concern about sufficient supply of services as America grows older and a greater percentage of the current physician workforce approaches retirement age. The direct impact of increased demand for care under a public option would exacerbate this situation on its own, but there are additional considerations that could impact the available supply of anesthesiology services.

Anesthesiologists are one of the higher compensated specialties.⁴² An approach that fixes payment rates across specialties at a set percentage of Medicare payments could have a significant negative impact on these salaries. If anesthesiology practices face significant revenue pressure on top of the demanding nature of practicing medicine, the overall number of anesthesiologists could decrease as some providers accelerate retirement and medical students choose less affected specialties, compounding the availability of providers to perform anesthesia services. Reduced revenues will likely require anesthesia service providers and those interested in the specialty to consider reduced income or increased workloads. It is worth noting that anesthesiologists may face a greater challenge with intentionally increasing their workload relative to other physicians, as the anesthesiologist does not typically directly drive service volume.

³⁵ See Table 11 in the final HHS Notice of Benefit and Payment Parameters for 2014 at 78 FR 15409.

³⁶ <https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>

³⁷ <https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/>

³⁸ <https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf>

³⁹ Anesthesiology is an integral part of intubation for ventilation, as described in <https://www.healthline.com/health-news/the-vital-and-dangerous-job-of-anesthesiologists-in-covid-19-fight> (Retrieved July 23, 2021)

⁴⁰ <https://www.gao.gov/assets/720/710326.pdf>

⁴¹ <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>

⁴² <https://www.medscape.com/slideshow/2020-compensation-anesthesiologist-6012720#3>

However, the increased demand for care could create the possibility of additional work for those anesthesiologists who may wish to take advantage of it and have capacity to do so.

One approach that anesthesia practices could also take in response to a public option is consolidation of practices, whether with other anesthesia practices or through mergers with hospitals. Both practices have been correlated with higher payment rates in the commercial market, which may provide a way for anesthesiologists and other affected providers to recover some of revenues lost under a public option. However, this would accelerate cost trends in the residual commercial market, which could in turn accelerate any potential shift of employer and individual market coverage into a public option.

At its core, the question of access to anesthesiology services may come down to whether or not there are sufficient anesthesiology providers to perform services. With tightening in both the marketplace and the anesthesiology workforce, the combination of a potential increase in demand under a public option and reduced revenues for practices has the potential to create a bottleneck in the provision of medical care, which could lead to reduced access to services requiring anesthesiology and an increased level of frustration with the medical system. To the extent that these effects are the result of broader anesthesiologist supply considerations, access issues would not necessarily be confined to the public option but could spill over into the commercial market and other government health care programs.

Methodology and data sources

In preparing this white paper, we performed four major technical tasks.

DETERMINE COMMERCIAL PAYMENTS AS A PERCENTAGE OF MEDICARE PAYMENT RATES

We utilized Milliman's Consolidated Health Cost Guidelines Sources + Database (CHSD+) for 2018, a proprietary database covering approximately 70 million commercial fully insured and self-funded lives. For claims that are adjudicable against the various Medicare Fee Schedules, we priced claims using the relevant fee schedule for 2018. We included area-specific adjustments to Medicare rates, and included outlier payments for facility claims. We did not reflect any exceptions to the typical schedules, including exceptions for inpatient services in Maryland, special payments for critical access hospitals and other facilities that are paid relative to Medicare cost data, or payments to facilities that reflect indirect medical education or disproportionate share payments.

For claims that are not adjudicable against the Medicare Fee Schedule, we calculated the average percentage of Medicare payments across commercial payers for in-network care across all Medicare-adjudicable services in each state by broad provider type separately for anesthesia and non-anesthesia procedure codes, and assumed that all such claims in a state are paid at the statewide percentage of Medicare. Overall, this methodology was applied to 7% of claims volume across commercial CHSD+.

We assume that claims that are currently provided out of network will continue to be out of network in the Market-Based Public Option and thus unaffected by public option considerations. In contrast, we handle these claims similarly to in-network claims for the Federal Public Option.

IDENTIFYING CERTAIN CLASSES OF CLAIMS

Using Milliman's *Health Cost Guidelines (HCGs)*, data in CHSD+ is classified into detailed service categories. Additionally, the data includes common claims indicators such as CMS specialty code and Healthcare Current Procedure Code System (HCPCS) identifiers for each service. We relied on the *HCGs* to identify claims by type of service (inpatient, outpatient, professional/other, and pharmacy).

To identify anesthesiology providers, we identified claims rendered by providers with specialty codes 05, 32, and 43. We did not attempt to identify any instances of "incident to" billing of anesthesia services, and relied upon the specialty code as reported. We also reviewed all anesthesia services, as indicated by CPT codes 00100 to 01999. We also include physical status modifier codes P1, P2, P3, P4, P5, and P6 as well as qualifying circumstances add-on codes 99100, 99116, 99135, and 99140, none of which Medicare currently recognizes for additional payment but which are typically paid under commercial anesthesia contracts. As this paper is focused on anesthesiologist payment rates, we focused on the specialty codes, but reviewed results against values for all anesthesia services as a reasonability check, as the CPT-based classification is more frequently used in similar literature. A significant component of anesthesia reimbursement is anesthesia time, which may be reported in minutes or in time units. The standard time unit is 15 minutes, but increments of 12 minutes, 10 minutes, and 8 minutes also exist in commercial contracts.⁴³ We assumed all claims which reported time units were based on a 15 minute time unit, which may minimally overstate Medicare payments as a percentage of commercial payments.

EVALUATING POTENTIAL PLAN DESIGNS

For the Federal Public Option, we have evaluated two plan design options – one loosely aligned with the fee-for-service

⁴³ Amongst respondents to the ASA's annual commercial conversion factor survey in 2018, 928 contracts used a 15 minute time unit, while just 34 used other time

Medicare benefit (Plan 1), and one aligned with the Biden-Sanders Unity Platform proposal with no deductible (Plan 2). These plan designs are described in Figure 16.

FIGURE 16: PLAN DESIGN OPTIONS FOR FEDERAL PUBLIC OPTION

	Plan Option 1	Plan Option 2
Deductible	\$500 (Medical) / \$400 (Pharmacy)	\$1,000 (all services)
Coinsurance	20% (Medical) / 25% (Pharmacy)	20%
Non-Deductible / Coinsurance Services ¹	Inpatient Facility Stays (\$1,250 copayment per admit)	All Deductible /Coinsurance
Out-of-Pocket Spending Limit (with Deductible)	\$8,550	\$6,000
Federal Actuarial Value	80.7%	80.9%

¹ We assume that ACA preventive services will be provided with no cost-sharing.

We evaluated plan designs using the 2021 Department of Health and Human Services (HHS) Actuarial Value Calculator. For the Market-Based public option, we evaluated three copay-based plan designs and three deductible / coinsurance plan designs at the gold, silver, and bronze metallic tiers, targeting the nominal

actuarial values of each metal tier as close as reasonably possible. These plan designs are described in Figure 17.

FIGURE 17: PLAN DESIGN OPTIONS FOR MARKET BASED PUBLIC OPTION

Plan	Actuarial Value	Deductible	MOOP	Cost-Sharing
Gold Copay	81.98%	\$500	\$5,250	Copays vary by service ¹
Silver Copay	72.06%	\$2,000	\$7,800	
Bronze Copay	64.46%	\$6,000	\$8,550	
Gold Coinsurance	79.62%	\$2,000	\$4,000	15% Coinsurance
Silver Coinsurance	70.87%	\$3,000	\$6,000	20% Coinsurance
Bronze Coinsurance	61.73%	\$7,000	\$8,550	40% Coinsurance

¹ For specific copays by service, please refer to the Cascade Care benefit descriptions referenced in footnote two.

Figure

Caveats, Limitations, and Qualifications

This white paper was developed to help ASA understand the potential range of impacts on anesthesiologist payments and anesthesiology service impacts under a range of public option proposals. This information may not be appropriate, and should not be used, for other purposes.

This report is provided for the use of ASA. ASA may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit, and assumes no duty or liability to, other parties that receive this work product. Any third-party recipient of this work product that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs. Any release of this report to a third party should be in its entirety. Milliman does not endorse any public policy or advocacy position on matters discussed in this report.

Please note that, in preparing our estimates, we relied upon a Milliman database of commercial healthcare expenditures, the Biden-Sanders unity platform published on July 8, 2020, parameters of the Cascade Care program, reports published by the Congressional Budget Office and the Joint Committee on Taxation, and various reports published by the Centers for Medicare and Medicaid Services, including the

projected National Health Expenditures for 2019 to 2028 and the 2020 Unified Rate Review public use file. Actual results will certainly vary for specific patients and healthcare providers due to differences in demographics, trends, discount arrangements, plan designs, utilization patterns, public option adoption rates, and public option parameters, among other factors.

Note that we did not attempt to evaluate every possible change in stakeholder behavior that may result from these potential program changes. Results will vary based on how individuals, providers, and other stakeholders react to the changes if implemented.

The authors are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report outlines the review and opinions of the authors, which are not necessarily those of Milliman. The terms of Milliman's client agreement with ASA dated January 15, 2020, apply to this information and its use.



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